

Referral For Chronic Pain Evaluation

Provider Note: A thorough history and physical examination will be performed to evaluate for multiple causes of pain.

Please fax the completed referral form, latest progress notes, diagnostic imaging reports, and patient demographics to (906)239-3223

REFERRING CLINICIAN				
Provider Name:		Practice/Clinic Name:		
Phone:		Fax:		
PATIENT DEMOGRAPHICS:				
Name:	DOB:	Pronouns/ Pref. Name:		
Address/ City/ State/ Zip:	Phone:			
	Email:			
CLINICAL HISTORY & DIAGNOSES				
Current Diagnoses Contributing to Pain: _____				
Pain Duration: _____				
COMORBID MENTAL HEALTH DISORDERS:				
☐ Major Depressive Disorder ☐ Generalized Anxiety Disorder ☐ Substance Use Disorder ☐ Bipolar Disorder		☐ Postpartum Depression ☐ OCD ☐ PTSD ☐ Other: _____		
Current & Failed Medications Used for Pain in the Past Year:	Max Dose Used	Start Date	Stop Date	Discontinued for side effects/lack of efficacy?
Other Past Treatments for Pain: (Physical Therapy, Injections/Blocks, Surgery, Chiropractic, Acupuncture, ect.): _____				
DIAGNOSTIC IMAGING & RECORDS				
Has relevant imaging been performed? (X-ray, MRI, CT, ect.) YES \ NO				
If yes, list dates & types: _____				
Is the patient able to get copies of records/imaging to our office ahead of appointment? YES/NO				

Provider Name: _____ Provider Signature _____ Date: _____